COUNTY OF LOS ANGELES
PUBLIC HEALTH
Acute Communicable Disease Control
313 N. Figueroa St., Rm. 212
Los Angeles, CA 90012
213-240-7941 (phone)
213-482-4856 (facsimile)
publichealth.lacounty.gov/acd/

Screening Form for Novel H1N1 ("Swine") Influenza Testing

(Effective as of 5/15/09)

ACDC ID: _____ VCMR ID: _____

Testing for Novel H1N1 influenza infection will only be done if the patient has (check all that apply):

☐ **Influenza-like illness (ILI) defined as fever ≥37.8ºC (100ºF) and a cough and/or sore throat and has + test for influenza A and is in at least one of the following categories:**

- ☐ **Admitted to hospital with ILI or sepsis-like syndrome**
- ☐ **Pregnant**
- ☐ **Part of an outbreak (specify_____)**
- ☐ **Healthcare worker**
  - **Place of employment: _____**
  - **Address, City. _____**

ACDC USE ONLY:
☐ Epi
☐ Other

All testing requires pre-approval by ACDC. Call 213-240-7941 and ask for the "doctor on call" for consultation before submitting a specimen to the Public Health Laboratory (PHL) or if a case is suspected novel H1N1, and does not meet the above case definition, but you are requesting testing. After obtaining approval from ACDC, fax the fully completed screening form to ACDC at 213-482-4856 and submit the specimen with specimen submittal form to the appropriate address on the PHL form (available at http://www.publichealth.lacounty.gov/acd/Diseases/Swine.htm).

Patient Name-Last	First	Middle Initial	Date of birth	Age	Sex

Address- Number, Street, Apt #	City	State	ZIP Code

Home phone	Work phone	Cell phone
( )	( )	( )

Race (check one)	Ethnicity (check one)
☐ African-American/Black ☐ Asian/Pacific Islander ☐ Native American ☐ White ☐ Other:_____	☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

Occupation	Student?
	☐ Yes ☐ No If Yes, Specify school. _____

Epidemiologic Information

☐ Onset of ILI within 7 days of close contact with a person who is a confirmed case of novel H1N1 influenza
☐ Healthcare worker (specify type and level of patient contact _____)

PRESENT ILLNESS

Onset date	Hospitalized? ☐ Yes ☐ No	Admit date	Discharge date	Medical record no.	Hospital Name

Level of medical care (check all that apply):

☐ Outpatient clinic ☐ Emergency Room ☐ Inpatient ward
☐ Intensive Care Unit ☐ None

Symptoms that occurred during current illness (check all that apply):

☐ Fever (≥ 37.8° C/100° F) ☐ Nasal Congestion ☐ Sore throat
☐ Cough ☐ Nausea/Vomiting/Diarrhea
☐ Muscle ache
☐ Other Specify: _____

Complications that occurred during acute illness (check all that apply):

☐ Pneumonia/ARDS ☐ Secondary bacterial pneumonia
☐ Bronchiolitis ☐ Encephalitis/encephalopathy
☐ Myocarditis ☐ Sepsis/Multi-Organ Failure
☐ Other Specify: _____

Died? ☐ Yes ☐ No If Yes, Date of death: _____

Significant past medical history:

	Yes	No	Unk
No underlying medical conditions ☐			
Cardiac disease……..	☐	☐	☐
Chronic pulmonary disorder (e.g. asthma, cystic fibrosis)	☐	☐	☐
Immunosuppression (e.g. HIV, malignancy) ……..	☐	☐	☐
Metabolic disorder (e.g. diabetes mellitus, renal)	☐	☐	☐
Developmental delay…..……	☐	☐	☐
Long-term aspirin therapy…..……..	☐	☐	☐
Steroids by mouth/injection…….....	☐	☐	☐
Cancer chemotherapy……	☐	☐	☐
Radiation therapy…..……..	☐	☐	☐
Pregnancy……..If Yes, specify # of weeks ____	☐	☐	☐
Other conditions..If Yes, specify. _____	☐	☐	☐

If Yes for any of the above, please specify in Remarks section.

Patient name (last, first) _____ Date of Birth _____ VCMR ID: _____

DIAGNOSTIC TESTS

Laboratory studies:

Chest X-ray: ☐ Positive ☐ Negative ☐ Not done Findings: _____

Other pertinent labs (LFTs, MRI/CT, etc.), if available. _____

Previous Influenza/Microbiology testing:

Type of microbiology test (check all that apply)	**Collection date**	**Influenza result**
☐ PCR		☐ Influenza A non-typable ☐ Influenza A typable ☐ Influenza B ☐ Neg
☐ Viral Culture		☐ Influenza A ☐ Influenza B ☐ Negative
☐ Rapid Influenza Test (EIA)		☐ Influenza A ☐ Influenza B ☐ Influenza A/B ☐ Neg
☐ IFA/DFA		☐ Influenza A ☐ Influenza B ☐ Neg
☐ Other: Specify. _____		

Other viral/bacterial pathogens detected? : ☐ Yes* ☐ No ☐ Unk

If yes*, specify source: ☐ Sputum ☐ ET asp ☐ BAL ☐ Pleural Fluid ☐ Blood ☐ Other, specify: _____

If yes*, specify pathogen: _____

Blood culture: ☐ Positive* ☐ Negative ☐ Not done

If Positive*, pathogen:_____

Respiratory culture: ☐ Positive* ☐ Negative ☐ Not done

If Positive*, specify specimen (n-p swab/wash, o-p swab, ET aspirate, sputum, BAL, pleural fluid) and pathogen: _____

_____

Other micro results: _____

REMARKS (include relevant medical history or outbreak information)

Date of Report: _____

CONTACT INFORMATION

Physician/Infection Preventionist Name	Facility	Pager/Phone number ( )	E-mail address

Fax this form to: Los Angeles County Department of Public Health
Acute Communicable Disease Control (ACDC) Phone 213-240-7941 Fax 213-482-4856